Protecting Rural Access to Care through Certificate of Need

April 11, 2022

Brian Floyd, RN, MBA
President, Vidant Medical Center
& Chief Operating Officer,
Vidant Health Hospitals

VIDANT HEALTH™

Our mission

To improve the health and well-being of eastern North Carolina

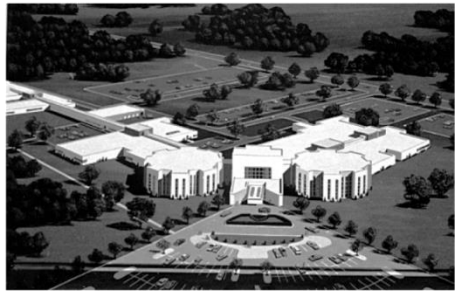
Our vision

To become the national model for rural health and wellness by creating a premier, trusted health care delivery and education system

Our values

Integrity
Compassion
Education
Accountability
Safety
Teamwork

Vidant/ECU History 1951-2007



1951 — Pitt County Memorial Hospital (PCMH), 120-bed hospital opened

1975 — PCMH and ECU School of Medicine signed first affiliation agreement

1977 — PCMH, 350-bed hospital opened on current site

1995 — PCMH and ECU renewed affiliation agreement

1997-1998 — University Health Systems incorporated; four community hospitals added

2002 — The Outer Banks Hospital opened

2007 — Electronic health record installed at PCMH

Vidant/ECU History 2009-2019

2009 — East Carolina Heart Institute at PCMH opened

2010 — Vidant Medical Group formed with 100 providers in 40 clinics

2012 — University Health Systems becomes Vidant Health; two community hospitals added

2013 — James and Connie Maynard Children's Hospital at Vidant Medical Center opened

2014 — Coastal Plains ACO formed

2018 — Eddie and Jo Allison Smith Tower opened

2019 — Halifax Regional Medical Center joins Vidant Health

Our System of Care Today

SERVING THE REGION

Hospitals

Vidant has eight hospitals including Vidant Medical Center—an academic medical center with two campuses and a level-1 trauma center—that serves as the teaching hospital for the Brody School of Medicine at East Carolina University.

Communities served

1.4 million people across 29 counties in eastern North Carolina

Clinics

More than 100 practice locations throughout the region

Total unique patients served

FY21 – 434,337

Beds

1,708 beds across the system

Babies delivered

FY21 – 6,188

Surgeries

FY21 – 49,992

Resources in Our Regional Footprint

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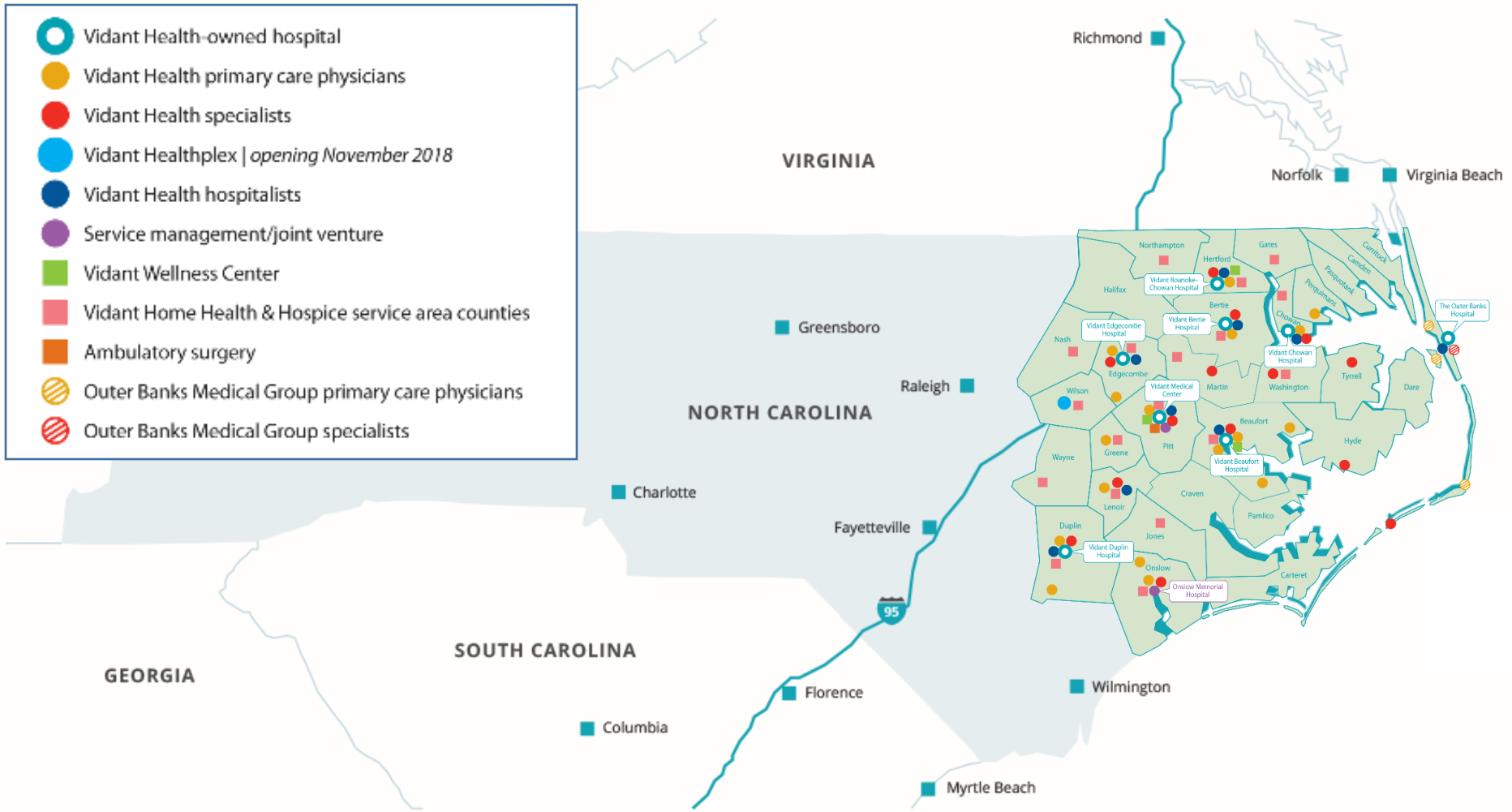


Our Next Chapter

We are stronger when we combine our collective expertise and energies to improving the health of eastern North Carolina

Working with Academic Partners

VIDANT HEALTH™

For more than 40 years the Brody School of Medicine has consistently – and cost-effectively – delivered on our legislatively-mandated mission to:

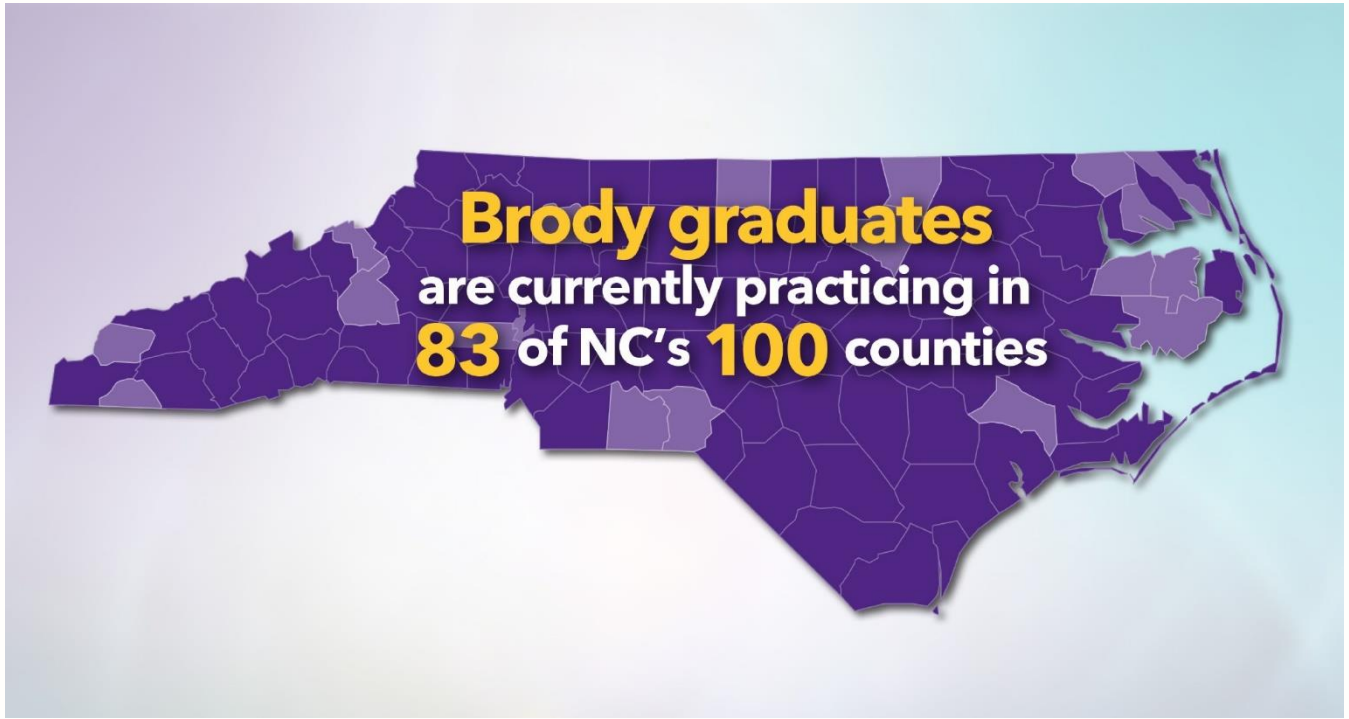
- Increase the supply of primary care physicians for our state
- Enhance access of minority and disadvantaged students to a medical education
- Improve the health status of citizens in Eastern North Carolina

North Carolina needs more of what Brody does

Working with Academic Partners

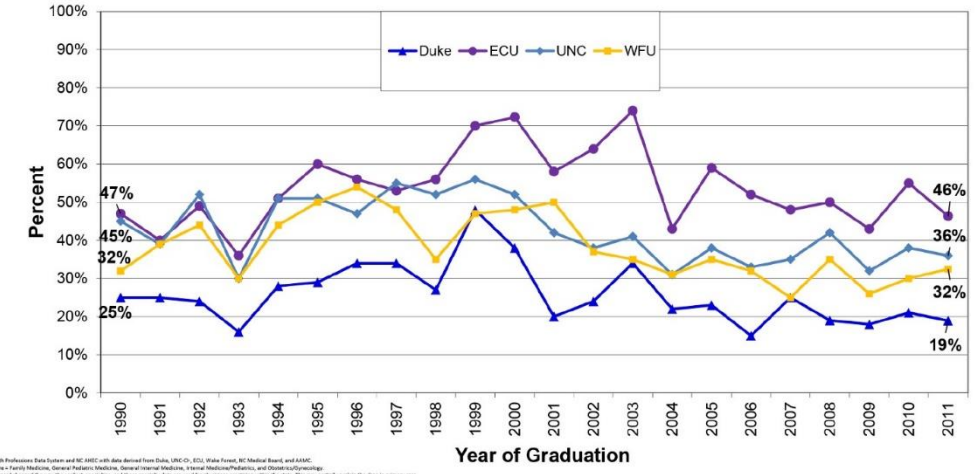
VIDANT HEALTH™

- 400+ Faculty Members
- 490 Brody School of Medicine Students
- 33 Residency and Fellowship Programs
  - 400 Resident Physicians/Fellows
- 1,755 Nursing Students Rotating Annually
- 51 Allied Health Programs
  - 680 Students Rotating Annually



HIGH PRIMARY CARE RETENTION

Percentage of North Carolina Medical Graduates (Classes 1990-2011)
Practicing in Primary Care Five Years After Graduation



ECU	46%
UNC	36%
WFU	32%
DUKE	19%

ECU BRODY SCHOOL OF MEDICINE

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Hill-Burton Act 1946

In 1946, Congress passed a law that gave hospitals, nursing homes and other health facilities grants and loans for construction and modernization. In return, they agreed to provide a reasonable volume of services to people unable to pay and to make their services available to all persons residing in the facility's area.

The program stopped providing funds in 1997, but about 140 health care facilities nationwide are still obligated to provide free or reduced-cost care.

Original Pitt Community Hospital
1924

Pitt Memorial Hospital
1951

Health Care Disparity in eNC

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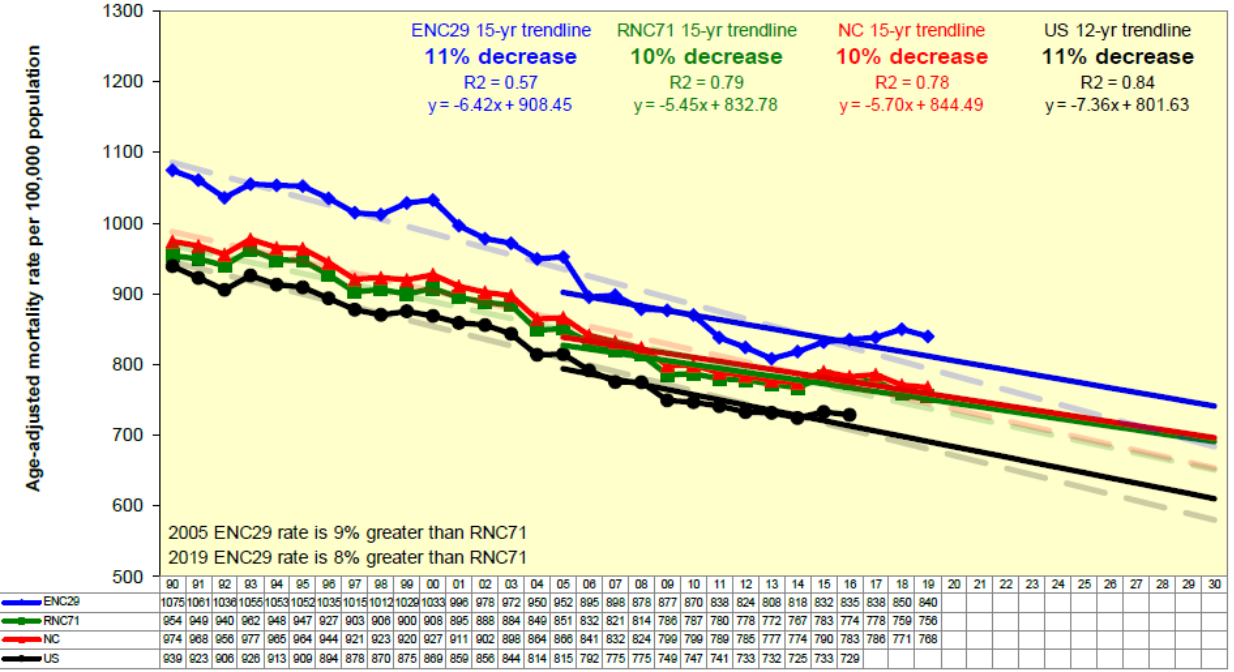
Figure 5.1 ii. All Causes of Death:
Trends in age-adjusted mortality rates for ENC29, RNC71, NC, and US,
1990-2019 with projections to 2030

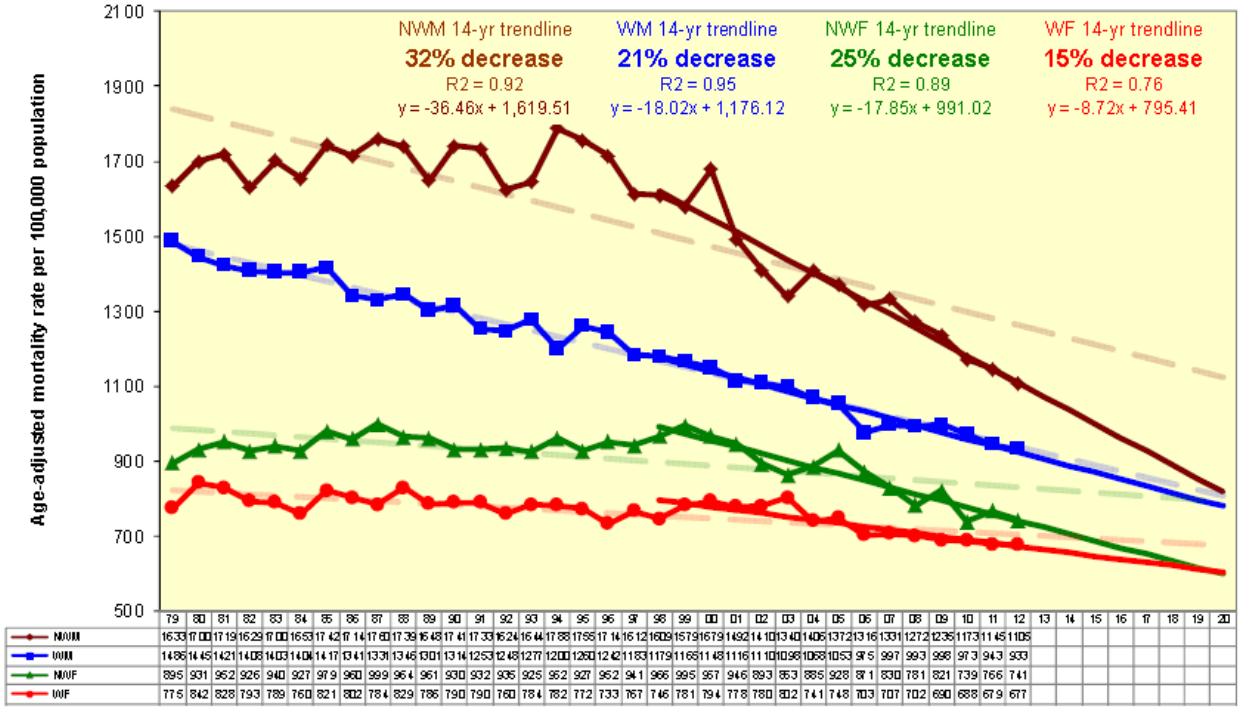


	90	91	92	93	94	95	96	97	98	99	00	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
ENC29	1075	1061	1036	1055	1053	1052	1035	1015	1012	1029	1033	996	978	972	950	952	895	898	878	877	870	838	824	808	818	832	835	838	850	840											
RNC71	954	949	940	962	948	947	927	903	906	900	908	895	888	884	849	851	832	821	814	786	787	780	778	772	767	783	774	778	759	756											
NC	974	968	956	977	965	964	944	921	923	920	927	911	902	898	864	866	841	832	824	799	799	789	785	777	774	790	783	786	771	768											
US	939	923	906	926	913	909	894	878	870	875	869	859	856	844	814	815	792	775	775	749	747	741	733	732	725	733	729														

Comparison of Fitted Rates in 2005				
ENC29	RNC71	NC	US	
	8% LT	7% LT	12% LT	ENC29
9% GT		1% GT	4% LT	RNC71
8% LT	1% LT		5% LT	NC
13% GT	4% GT	5% GT		US

Comparison of Fitted Rates in 2019				
ENC29	RNC71	NC	US	
	8% LT	7% LT	15% LT	ENC29
8% GT		1% GT	8% LT	RNC71
7% GT	1% LT		9% LT	NC
17% GT	8% GT	9% GT		US

Figure 5.1 iii. All Causes of Death:
Trends in age-adjusted mortality rates by race and gender for ENC29,
1979-2012 with projections to 2020



	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	00	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20
NWM	1633	17 00	17 19	16 29	17 00	16 53	17 42	17 14	17 60	17 39	16 48	17 41	17 33	16 24	16 44	17 88	17 65	17 14	16 12	16 09	15 79	16 79	14 92	14 10	13 40	14 06	13 72	13 16	13 31	12 72	12 35	11 73	11 45	11 05								
WM	1486	14 45	14 21	14 08	14 03	14 04	14 17	13 41	13 31	13 46	13 01	13 14	12 53	12 48	12 77	12 00	12 60	12 42	11 83	11 79	11 66	11 48	11 16	11 10	10 98	10 68	10 53	9 75	9 97	9 93	9 98	9 73	9 43	9 33								
NWF	895	931	952	926	940	927	979	960	999	964	961	930	932	935	925	952	927	952	941	966	995	957	946	893	853	885	928	87 1	830	781	821	739	766	741								
WF	775	842	828	793	789	760	821	802	784	829	786	790	790	760	784	782	772	733	767	746	781	794	778	780	802	741	748	703	707	702	690	688	679	677								

Comparison of Fitted Rates in 1999				
NWM	WM	NWF	WF	
	27% LT	39% LT	51% LT	NWM
38% GT		16% LT	32% LT	WM
63% GT	19% GT		20% LT	NWF
104% GT	48% GT	25% GT		WF

Comparison of Fitted Rates in 2012				
NWM	WM	NWF	WF	
	18% LT	34% LT	40% LT	NWM
22% GT		19% LT	28% LT	WM
51% GT	24% GT		10% LT	NWF
68% GT	38% GT	11% GT		WF

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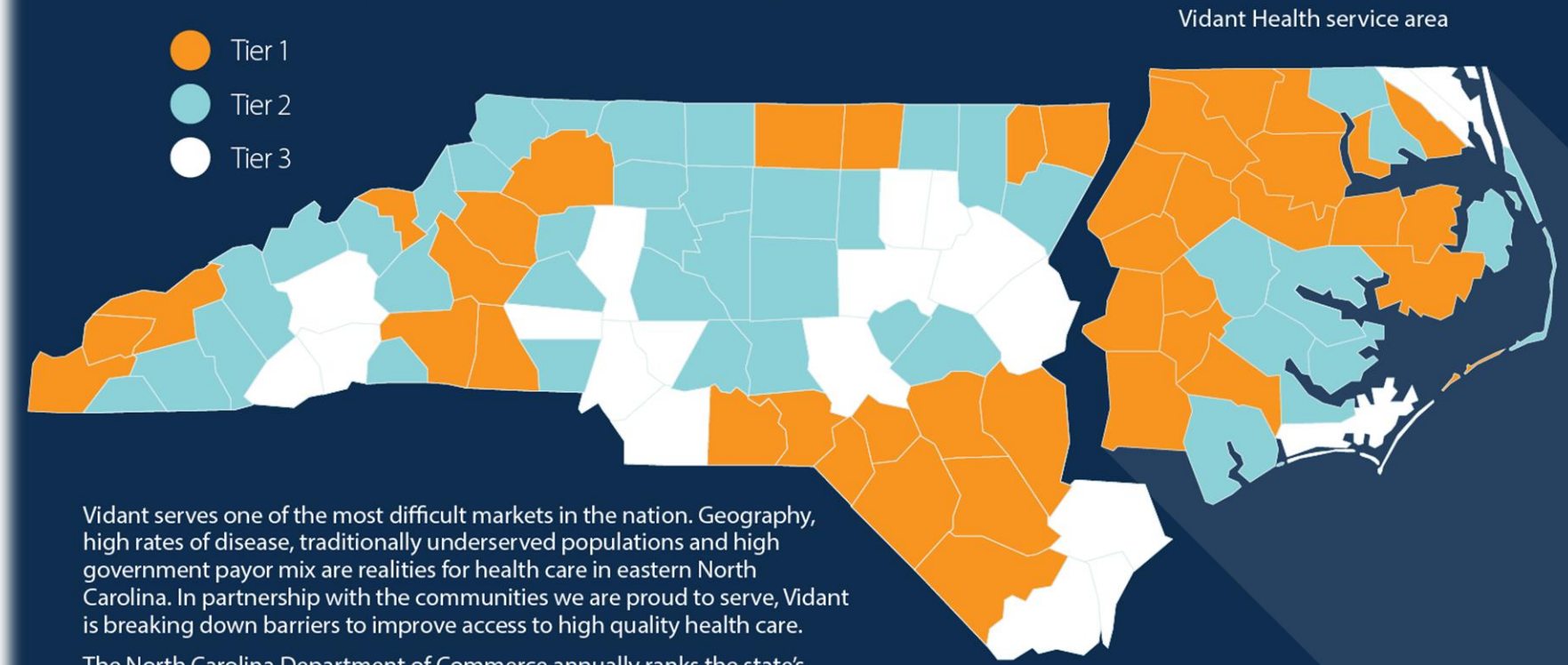
2022 County Distress Rankings

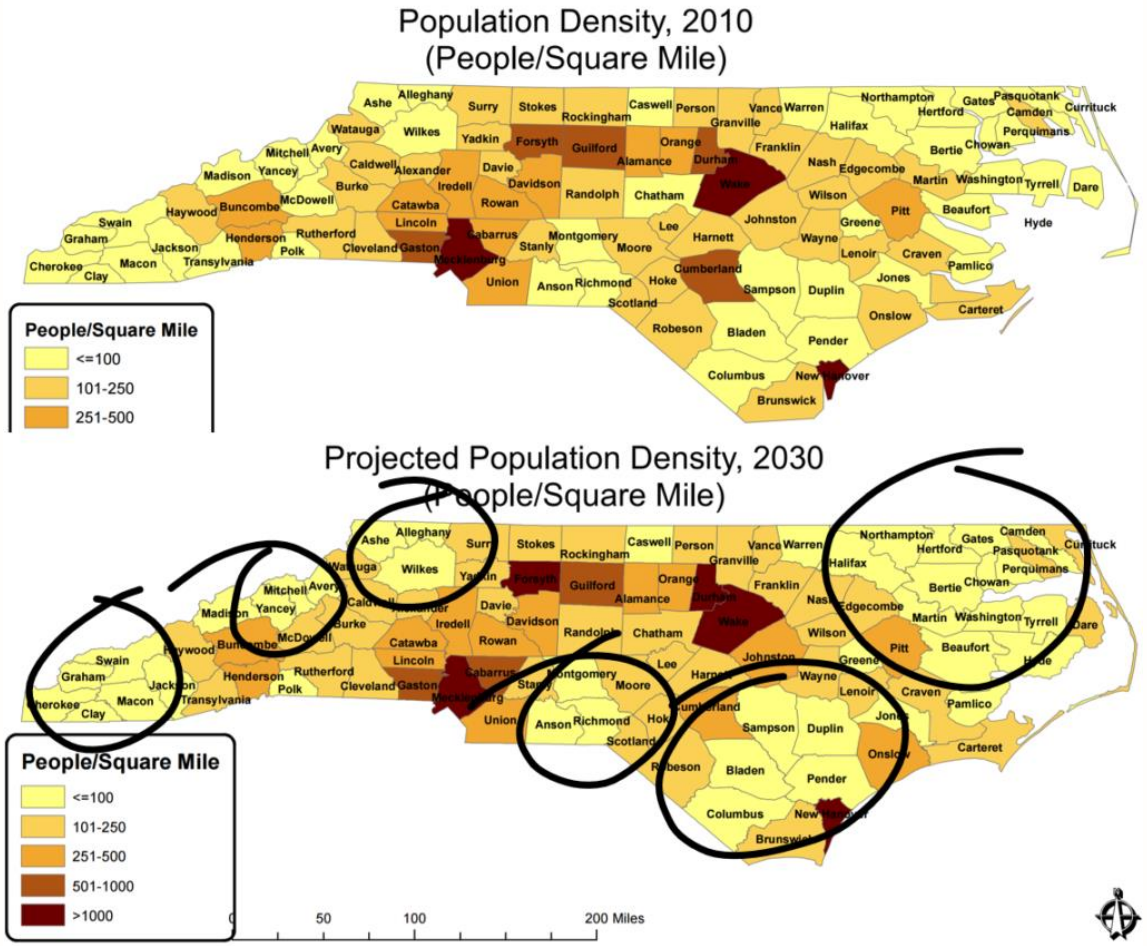


Vidant serves one of the most difficult markets in the nation. Geography, high rates of disease, traditionally underserved populations and high government payor mix are realities for health care in eastern North Carolina. In partnership with the communities we are proud to serve, Vidant is breaking down barriers to improve access to high quality health care.

The North Carolina Department of Commerce annually ranks the state's 100 counties based on economic well-being and assigns each a Tier designation. This Tier system is incorporated into various state programs.

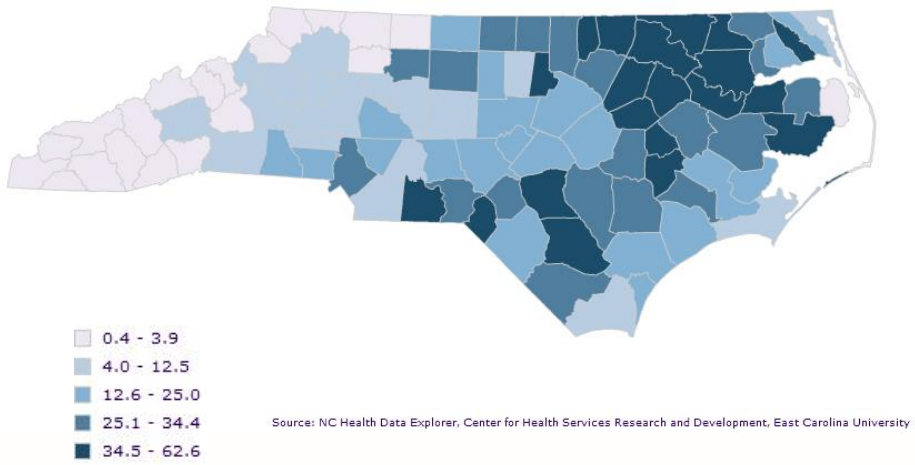
The 40 most distressed counties are designated as Tier 1, the next 40 as Tier 2 and the 20 least distressed as Tier 3.

Rural Health



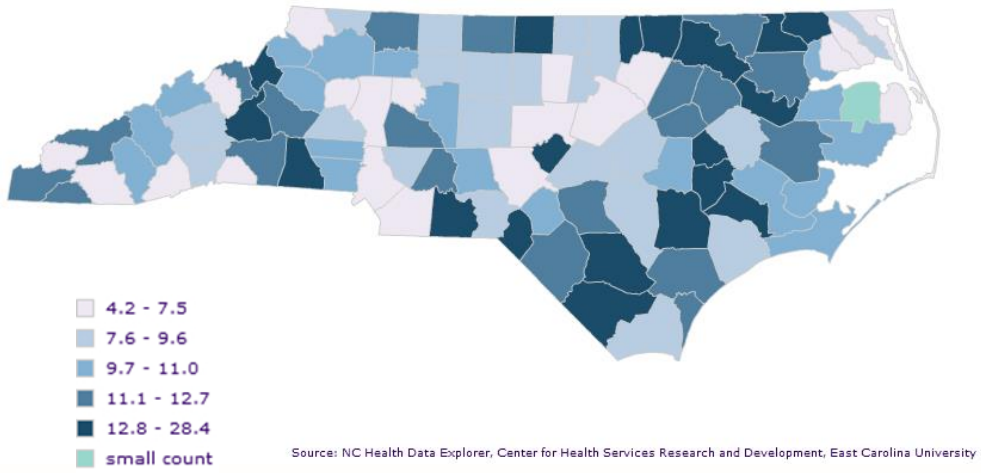
Social Determinants

Percent Non-White Individuals (2009 - 2013)



Source: NC Health Data Explorer, Center for Health Services Research and Development, East Carolina University

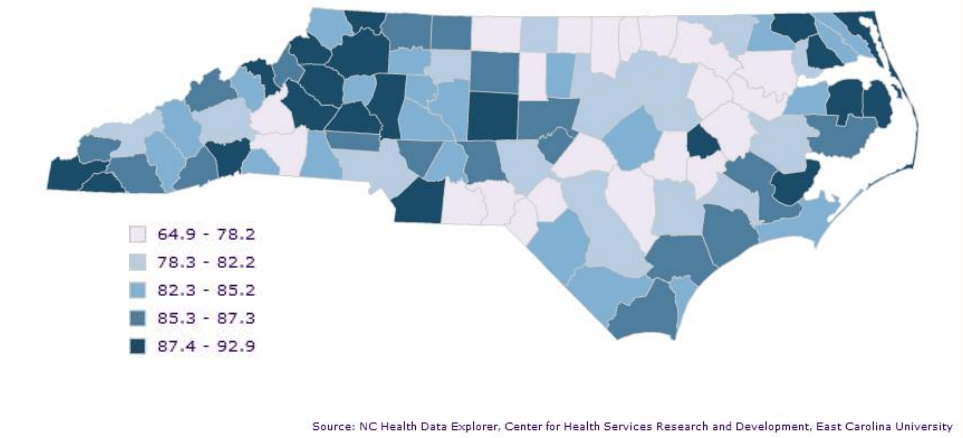
Disease Prevalence – Percent All Ages (2006 – 2010)



Source: NC Health Data Explorer, Center for Health Services Research and Development, East Carolina University

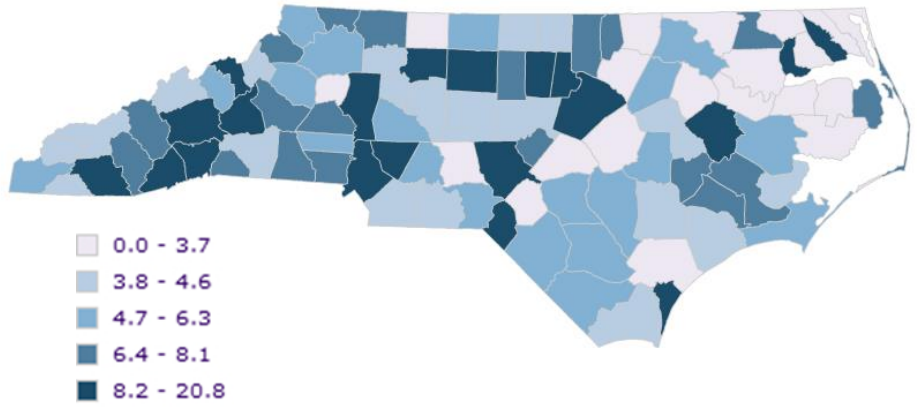
Social Determinants

High School Graduation Rate (2013) (Percent of Students)



Source: NC Health Data Explorer, Center for Health Services Research and Development, East Carolina University

Primary Care Physicians per 10,000 (2012)



Source: NC Health Data Explorer, Center for Health Services Research and Development, East Carolina University

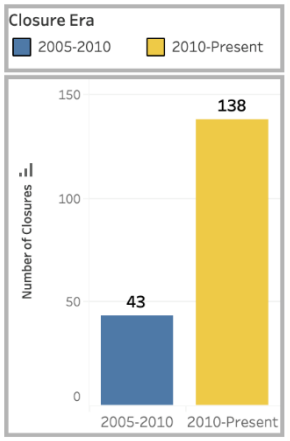
Hospital Closures

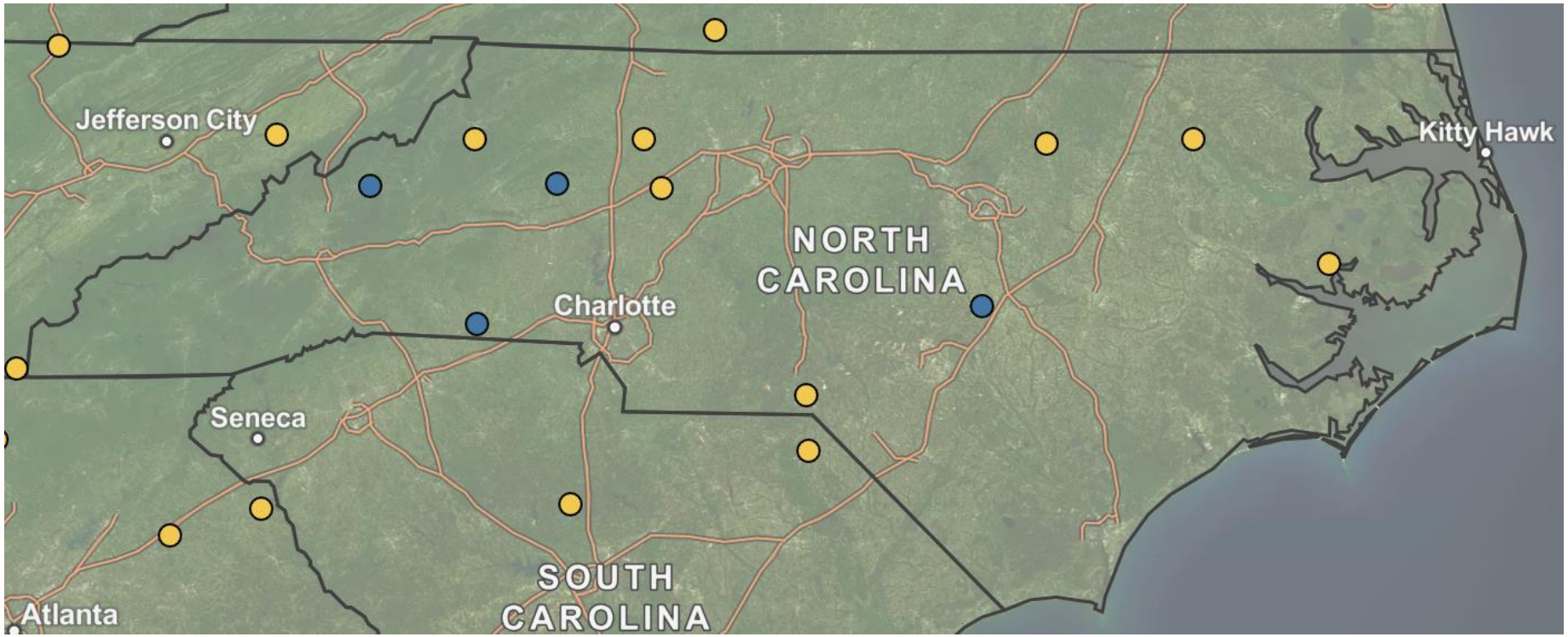
181 Rural Hospital Closures since January 2005

98 complete closures* + 83 converted closures**

138 closures since 2010

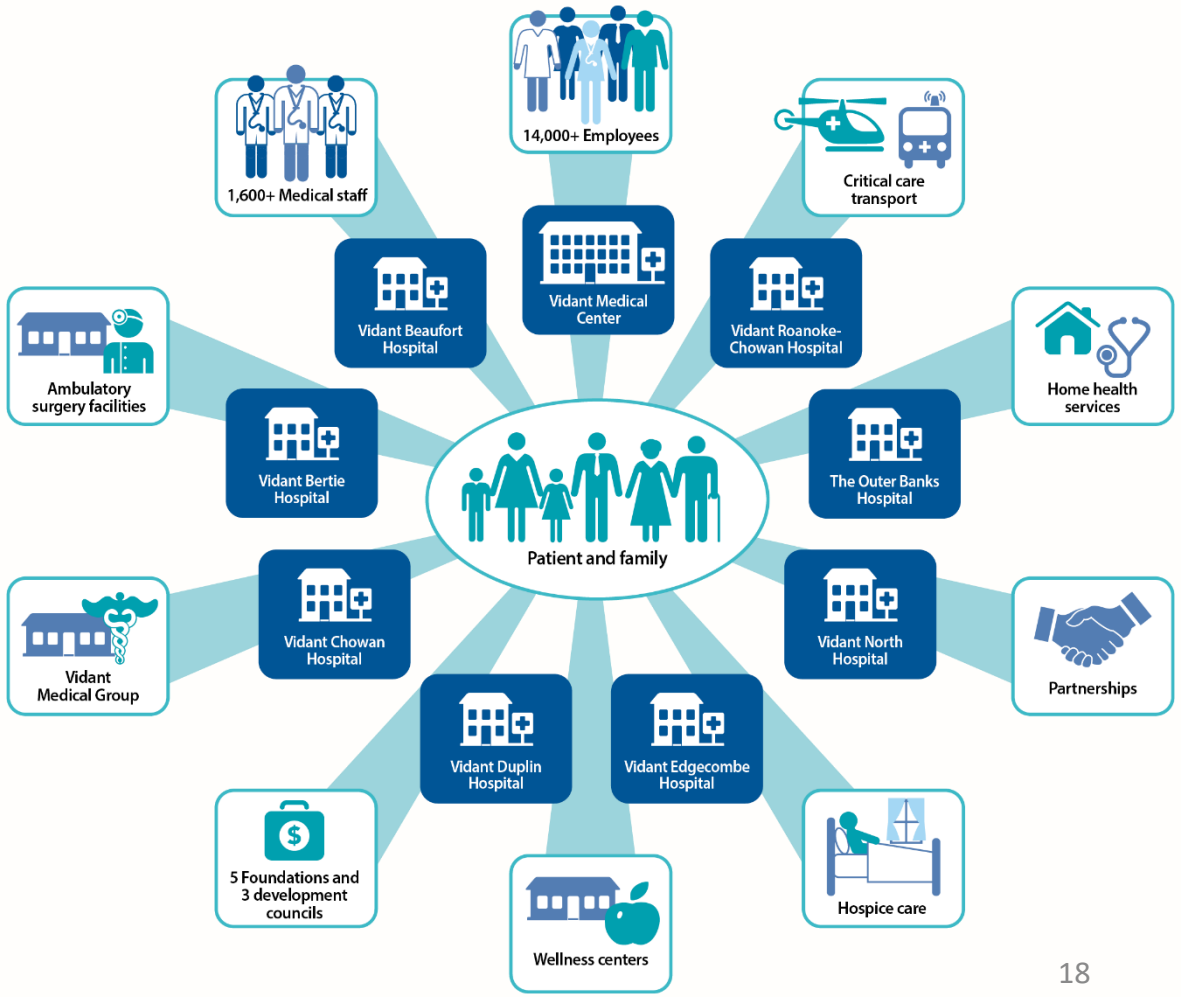
** facilities no longer provide healthcare services ** facilities no longer provide in-patient care, but continue to provide some healthcare services [e.g., primary care, Rural Emergency Hospital (REH), skilled nursing care]*





Source: https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/

Integrity of Care



Government is Dominant Payor

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- More than 67% of healthcare is funded by the government
  - Compared with 58% on average across the country for other teaching hospitals
  - Government rates are set *below* the cost to deliver the service
  - This gap is supposed to be filled by patients with commercial insurance: *cost shifting*

Payor Mix and Reimbursement

- 10%-12% of patients have no insurance and no means to pay for their care
- Commercial insurance covers about 20% of the patients cared for by Vidant Health
- *All payments by all payers are being cut*
  - Medicare
  - Medicaid
  - Commercial

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Uncompensated care*

*Based on most recent available data

FY	Charity	Bad debt	Total charity and bad debt	Medicaid losses	Medicare losses	Total uncompensated care
2020	$93,149,684	$50,990,359	$144,140,043	$14,976,584	$102,761,447	$261,878,074
2019	$68,929,025	$56,829,803	$125,758,828	$9,808,676	$130,253,069	$265,820,573
2018	$61,416,824	$46,135,124	$107,551,948	$18,296,639	$91,196,115	$217,044,702
2017	$54,786,932	$43,268,554	$98,055,486	$19,786,844	$83,190,578	$201,032,908
2016	$53,528,158	$34,548,542	$88,076,700	$33,902,707	$72,940,386	$194,919,793

Assistance

- Vidant offers charity care to eligible patients who are unable to pay due to financial hardships
- Vidant assists patients in determining eligibility for Medicaid and in applying for other government-assisted programs

Percentage of Margin Urban vs. Rural

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Figure 1: 2014 CAH, ORH and Urban Median Total Margins by Census Region

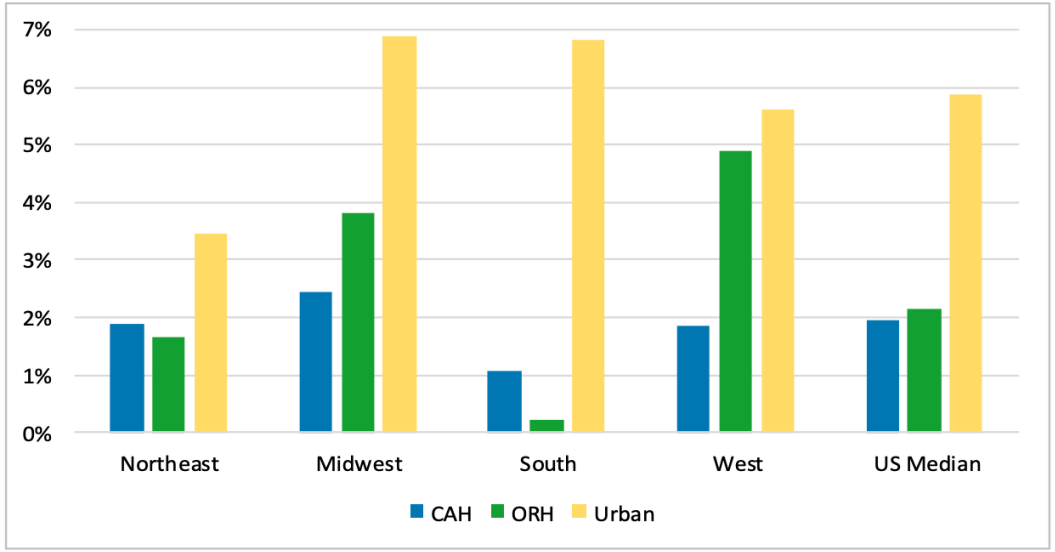

Table 1: Number of Hospital Medicare Cost Reports, Fiscal Year 2014*

	Northeast	Midwest	South	West	**US**
CAH	61	595	292	251	**1199**
ORH	93	212	435	113	**853**
Urban	358	454	748	384	**1944**
Total	**512**	**1261**	**1475**	**748**	**3996**

*These are the number of hospitals having total margin values for Medicare Cost Reports falling within fiscal year 2014 and having at least 360 days in production.

Source:https://www.shepscenter.unc.edu/wp-content/uploads/dlm_uploads/2016/03/Geographic-Variation-in-the-Profitability-of-Urban-and-Rural-Hospitals.pdf

VIDANT HEALTH™

INVESTING IN THE REGION

Economic impact

13,500

Jobs

Vidant employs more than 13,500 community members

$1.2 billion

Investment in team members

Vidant invested more than $1.2 billion in team member payroll and benefits in FY21

$14.8 million

Foundation impact

Allocated $14.8 million in 2020 for cancer care equipment, pediatric services, patient medical needs, team member support and other health care initiatives across eastern North Carolina

Certificate of Need

How it works in NC

- State Health Coordinating Council (SHCC) works with staff to examine population and health trends in every county/region of NC.
- Often revises need methodologies prior to a new annual plan
- Publishes annual State Medical Facilities Plan, signed by Governor
  - Can be modified any time during the process, including by the Governor
- Once published, identified need is awarded to applicants via a CON.

Certificate of Need

How it works in NC

The current healthcare environment is designed with a range of payments for services that span the highly profitable to the not-so-profitable.

"Cherry Picking" highly profitable (ambulatory surgery, diagnostic imaging, cardiac catheterization) services from hospitals means facilities will be forced to make tough decisions on those services that are not-so-profitable (neonatal, behavioral health, ED, trauma, chronic disease management, wellness, general medicine services, etc.).

Observations/Conclusions

- Hospitals rely on revenues from outpatient surgeries to offset losses from other hospital operations -- the mission services that we provide because our community needs them but for which reimbursement is inadequate.
- Rural Hospitals are the economic engine for their region - ECU Health has an economic impact of $4.0 billion on Eastern North Carolina
- Rural Health Care is much different than in urban environments – with lower operating margins with less commercial paying business and different social determinants of health

Appendix

Economic Impact Study-2021

North Carolina Impact _ Vidant Health

Impact Type	Employment	Labor Income	Value Added	Output
Direct Effect	13,755.1	$1,210,234,601	$1,328,596,145	$2,073,570,118
Indirect Effect	7,925.0	$349,420,023	$513,382,403	$1,070,427,913
Induced Effect	6,503.6	$244,054,261	$494,220,618	$874,996,340
Total Effect	28,183.7	$1,803,708,885	$2,336,199,166	$4,018,994,371
Total Effect Multiplier	2.05	1.49	1.76	1.94

Table 5

State of North Carolina Operational Impact

2021

Combined Operations				
Impact Type	**Employment**	**Labor Income**	**Value Added**	**Output**
Direct Effect	15,664.0	$1,474,457,221	$1,607,231,413	$2,199,199,197
Indirect Effect	8,296.1	$364,553,270	$539,125,168	$1,128,885,496
Induced Effect	7,732.0	$291,710,777	$589,525,196	$1,041,192,048
Total Effect	31,692.3	$2,130,721,258	$2,735,881,768	$4,369,276,736
	1.94	1.41	1.63	1.78